Enrolment for Adolescent Oral Health Services

This is not a consent to treatment form.

MINISTRY OF HEALTH
MANATŪ HAUORA

New enrolment ☐ Change of dentist ☐

To be completed by agreement holder

Name of dentist

Revive A Smile

Agreement number

3 5 5 3 2 3

We agree to provide oral health services to the patient named on this form as specified in our agreement.

Signature of dentist

Date

Payee number

7 1 3 4 2 0

Agreement holder's name

Dr. Assil Russell

District health board

Waikato

Address

608 River Road
Chartwell 3214
Hamilton

To be completed by legal guardian or patient

If Year 9 and above, give this form to the dentist you have chosen.

NHI number (mandatory)

Patient's last name(s)

Patient's first name(s)

Date of birth

Sex

Male ☐ Female ☐

School year

Full residential address

Telephone number (day)

Mobile

Postcode

Secondary school / educational institution to be attended

I wish the person named above to be enrolled for oral health services with the agreement holder named.
Patient details and clinical information may be provided on request to the local district health board and the Ministry of Health.
If this is a transfer between dental providers, the previous dentist may be informed that this has taken place.

Full name of legal guardian or patient

Signature of legal guardian or patient

Date

Please return to: Ministry of Health, Private Bag 3015, Whanganui Mail Centre, Whanganui 4540.

HP 5956
February 2016